

# Insurance Complaint Form

**Please complete all sections of this form** so that we can review your insurance problem. Please Return the completed form to: Consumer Services Department of Financial Regulation, 89 Main Street, Montpelier, VT 05620-3101. If you wish to fax your completed form, our fax number is 802-828-1446.

Do you have an attorney handling this matter for you? ☐ Yes ☐ No  
**If you answered yes, stop here.** We cannot accept this form without written approval from your attorney.

**Complainant's Name:**

**Telephone number(s)** [where we can reach you during business hours or leave a message]:

**Email Address:**

**Street Address/P.O. Box:**

**City:**

**Zip Code:**

**Name of Insurance Company**

**Policy Number:**

**Claim Number(s):**

**Date(s) of Loss**

**Date of Service(s):**

**Type of Service(s):**

Type of Coverage (check one):

- ☐ Auto ☐ Homeowners ☐ Commercial ☐ Life ☐ Annuity ☐ Other  
☐ Comprehensive/Major Medical ☐ Catamount Health ☐ Disability ☐ Dental ☐ Long Term Care  
☐ Other Health (such as limited benefit, accident, student): \_\_\_\_\_  
☐ Medicare Supplement ☐ Medicare Part C or D

Is this a: ☐ Group Policy ☐ Individual Policy

*If you also want to file the complaint against an insurance agent or broker, please complete the following information:*

**Agent/Broker Name:**

**Telephone #:**

**Address** (include street, P.O. Box, City, State and Zip Code)

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## CONSENT TO RELEASE INFORMATION

I, \_\_\_\_\_, request and authorize my insurer(s) and any agent or broker named in this form and their contractors to disclose any and all information relevant to this complaint to the Vermont Department of Financial Regulation for investigation and follow-up related to my complaint. Relevant information may include medical records or other medical information, including records or information concerning treatment for mental health, alcohol or drug abuse, or sexually transmitted infections.

The Department has my permission to exchange any information I provide to the Department with my insurer(s), agent/broker and their contractors if relevant, and any representative or other person I have named below.

**My representative for purposes of this complaint is:**

\_\_\_\_\_

**I do not have a representative, but I want the Department to be able to discuss my complaint with** (for example, family member or friend, health care provider, attorney, agent/broker, etc.).

Please identify:

\_\_\_\_\_

\_\_\_\_\_  
**Signature of Insured**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent or Guardian**  
(or other person authorized to sign)

\_\_\_\_\_  
**Date**

You may revoke this consent at any time unless the Department or any person or entity named above has already taken action in reliance on it. If not revoked previously, this consent will terminate upon the Department's closure of this complaint or when the Department has completed any needed follow-up.

**PLEASE DESCRIBE YOUR PROBLEM IN DETAIL. ATTACH ADDITIONAL PAGES, IF NECESSARY. PLEASE INCLUDE COPIES (DO NOT SEND ORIGINALS) OF ALL IMPORTANT PAPERS, LETTERS OR OTHER DOCUMENTATION RELEVANT TO THIS MATTER.**

**WHAT WOULD YOU CONSIDER TO BE A FAIR RESOLUTION OF YOUR PROBLEM?**